Picking Patients for Profit: Admissions Discrimination in Nursing Homes

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April 19, 2022

About Me

- Assistant Professor at the UCLA Anderson School of Management
- Health economist
- Research:
  - Admissions discrimination
  - Nursing home workforce
  - Nursing home finance
  - COVID-19
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What I'm Going to Tell You

- Admissions discrimination is **widespread**.
  - 19% of residents (40% of days) aren't at their first-choice nursing home
  - Beds are available, *just not available to them*.
- Evidence consistent with discrimination on Medicaid, stay length, disability, and race.
- Policy solutions aren't obvious.
  - Unintended consequences and ineffective

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Access Matters

- Large variation in whether facilities had COVID-19 outbreaks.
  - Many contributing factors such as size, location, staffing, etc.
  - Access to a smaller facility, a better-resourced facility, or a better-located facility could reduce your risk dramatically.
- Important long before COVID
  - 1% less staff -> +1.9% mortality (.15 pp)
    - Friedrich and Hackmann (2021)

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Disability Discrimination

Disclaimer: I am not a lawyer.

- Disability discrimination is **clearly illegal**
  - Rehabilitation Act
  - American with Disabilities Act
  - Fair Housing Act
- Example: Wagner v. Fair Acres
- Exception: if care cannot be provided.
  - Grubbs v. Medical Facilities of America

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Medicaid Discrimination

Clear **intention** to ban it (1987 NHRA):

"Not request or require residents or potential residents to waive their rights… including but not limited to their rights to Medicare or Medicaid."

"Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits."

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Medicaid Discrimination

- *Potential Loophole:* deny admission without asking resident to forgo Medicaid.
  - Clear violation of the intent of the law.
  - Possibly satisfies the letter of the law.
- No good caselaw.
  - Lack of awareness.
  - Lack of representation.
  - Facilities back down when challenged.

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A Role for Advocates

- My research shows these problems are prevalent, but that's not enough.

- Lawmakers and regulators need to do more.
  - Regulators need to take a *clear stance*.
    - Little case law, and HHS OCR, MACPAC, etc., won't advise on the record.
  - Ombudsmen: "Not really on our radar." and "I wouldn't even know what box to check."
  - HHS survey (1999): only 4% of Medicaid officials think financial screening happens with any frequency (70% of discharge planners)

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Study Overview

- **Data:** All residents admitted to CA nursing homes between 2004 and 2007.
  - Assessments, claims, enrollment
- **Key challenge**: We don't see applications or know where residents wish they could have gone.
  - How do we prove there's discrimination?
  - Residents on Medicaid and with disabilities live in different geographic areas and *may even have different preferences*.

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Identifying Discrimination

- **Idea:** Look for patterns consistent with strategic discrimination.
  - Smart facilities will discriminate more when fewer beds are available.
  - Study identifies discrimination based on this.
- **Discrimination Test**: Do the *same facilities* admit different patients depending on how full they are?

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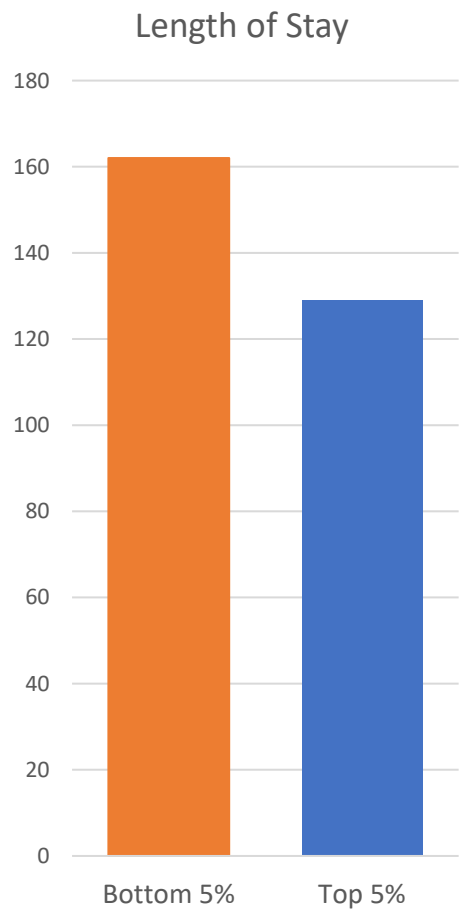
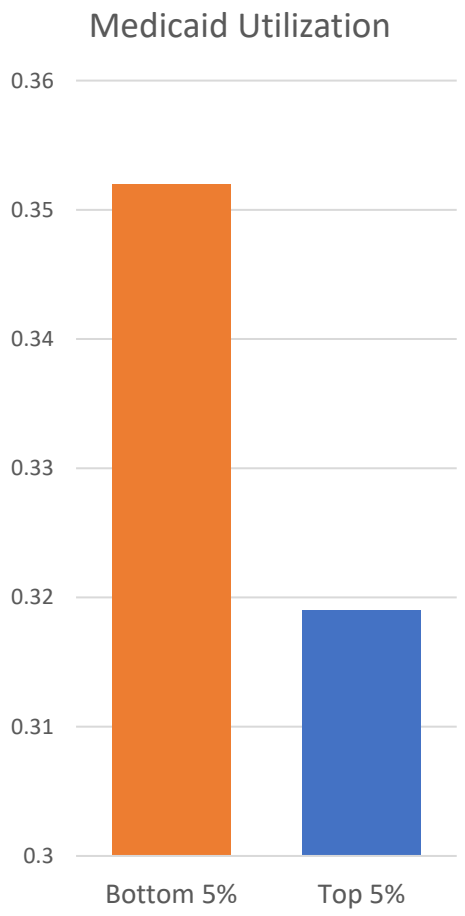
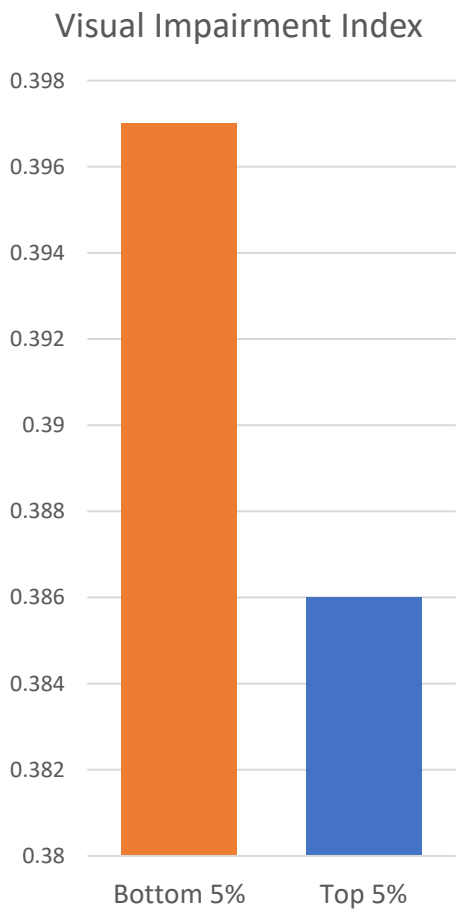
Simple Evidence







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Machine Learning

- **Challenge:** Residents have many characteristics: payment source, care needs, race, gender, age, etc.
- **Idea:** Ask a computer to "learn" from the data who is discriminated against based on what types of patients are typically admitted when less full.

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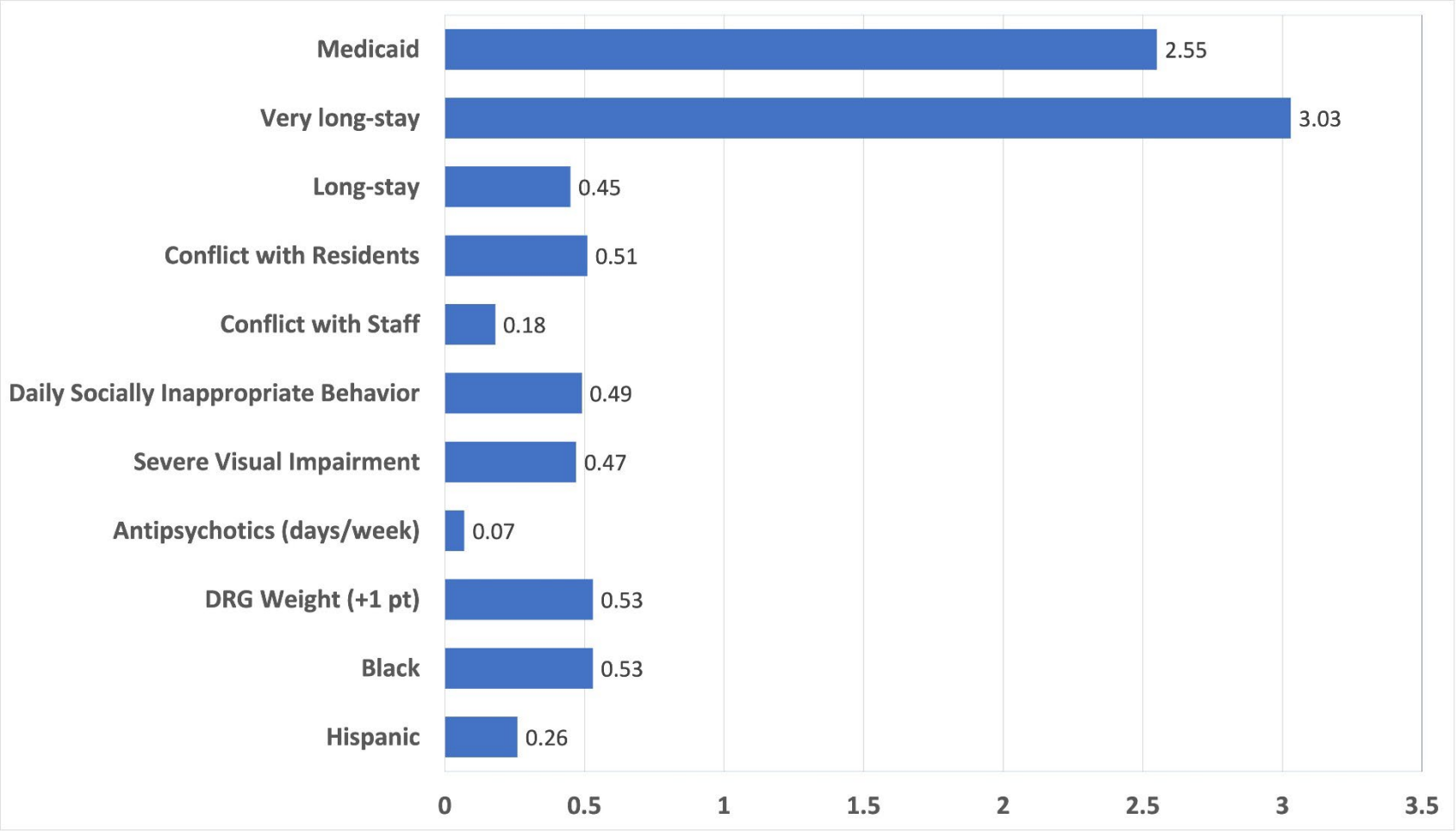
Discrimination "Points"



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Modeling and Policy Analysis

- **Idea:** statistically fit an economic model of residents' preferences over facilities and facilities' preferences over residents.
  - Common in economics research (especially competition/antitrust).
  - Now common in industry (Amazon, Uber, etc., all have teams that do this).
- **Value:**
  - Precise measurement of the problem.
  - Simulate alternative regulation and policy.

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Measuring the Problem

- 19% are not at their first-choice facility.
  - Higher for very long-stay Medicaid (49%)
- Medicaid beneficiaries would gain a lot of value from better access.
- Medicaid beneficiaries do care 35% less about RN staffing.
  - Though, they care much more than naïve approaches would infer.

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Alternative Policies

- **First come, first served**
  - Large benefits to Medicaid residents: $10.09/day
  - Small harms to short-stay Medicare patients
- **Raising Medicaid reimbursements**
  - Matching private-pay costs $37.26 per Medicaid day and is valued at $0.72.
  - Access alone isn't worth it. (Need improvement.)
- **Expanding Capacity**
  - Benefits both Medicaid and non-Medicaid patients and benefits can exceed costs.
    - San Diego (+800 beds): $11,544/day cost, $27,384/day benefit

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Nursing Home Staff Turnover

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Staff Turnover is Really High

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Turnover Greater than 100%?!?!

- **Our measure**: fraction of care-hours that turn over during a year.
- *100% doesn't mean everyone left!*
- Same role can turn over multiple times.
- Most facilities have a mix of "permanent" and short-term staff. Short-term staff turn over *a lot.*

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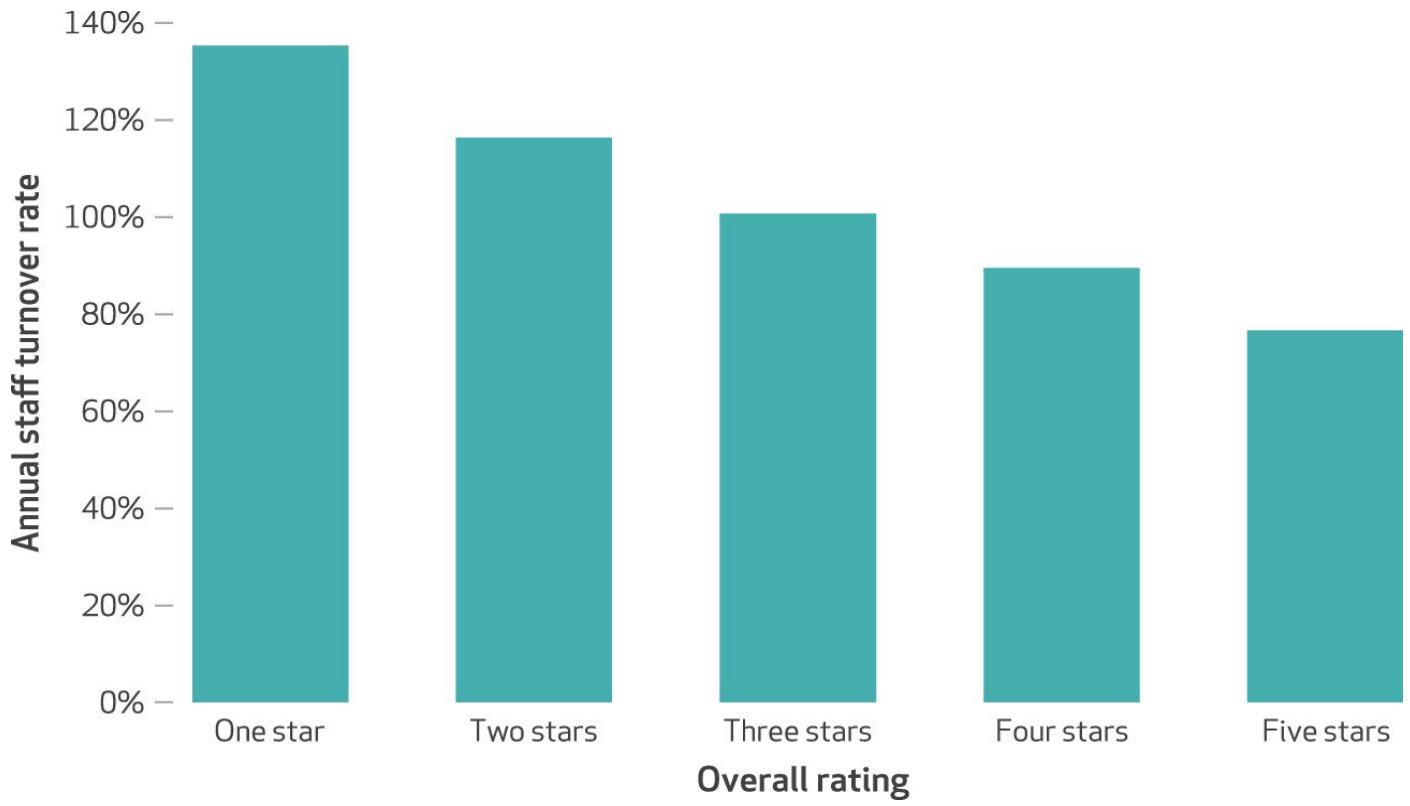
High Turnover is a Bad Sign



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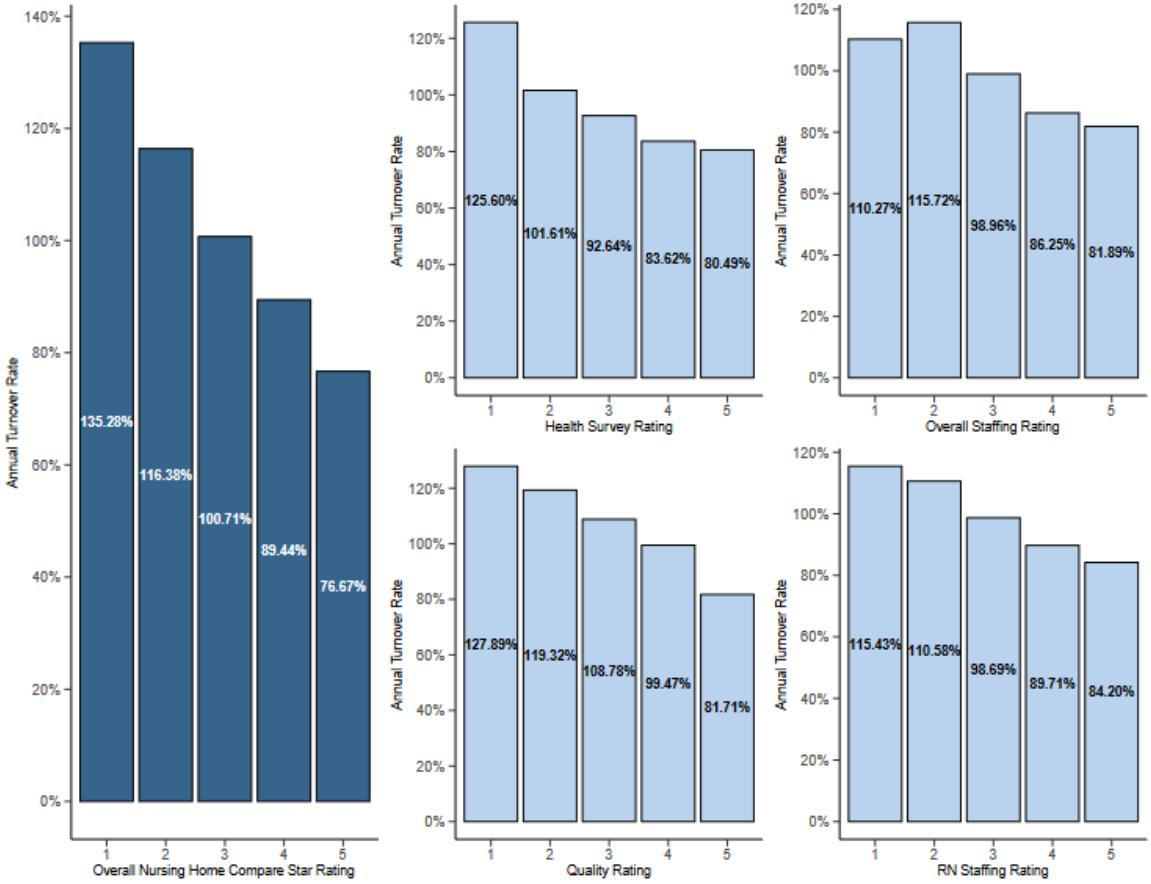

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High Turnover is a Bad Sign

- Turnover is associated with lots of indicators for concern:
  - High Medicaid utilization
  - Low income
  - For profit
  - Chain owned

- Mounting evidence that turnover causes worse outcomes.
  - More infection control violations after turnover
  - More evidence to come!

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High Turnover Made Headlines

- Thanks to great reporting, our work on high turnover made headlines and even got cited in Congressional hearings.

- But this shouldn't have been news.
  - ACA mandated that CMS publish turnover/retention measures
  - CMS just ignored this requirement
  - HHS OIG published a report urging CMS to report turnover just weeks after our paper.

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Success! Turnover Is Now On Nursing Home Compare

Total nursing staff turnover

Lower numbers are better

59.1%

National average: 51.6%

California average: 44.3%

Registered Nurse turnover

Lower numbers are better

76.5%

National average: 49.8%

California average: 49%

Number of administrators who have left the nursing home

Lower numbers are better

3

National average: 1.1

California average: 0.8

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Changing the Ways We Measure and Reward Staffing

- As we learn more, it's worth asking:
  - Is hours per patient day the right measure?
  - What are the indicators of good staff?
  - Does a consistent care team help residents?
  - Can we reward high quality staffing and not just staffing levels?
- CMS is including turnover in star ratings.
- States may do even more:
  - Multiple state health departments have reached out about our research.
  - One is considering adjusting reimbursements based on staffing tenure.

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Thanks!

Don’t hesitate to reach out.

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